DEPARTMENT OF HEALTH
AND HOSPITALS
Aging and Adult Services

MDS-HC Assessment and Care Planning Training Registration Form

TRAINEE NAME:	**TITLE:**
TRAINEE EMAIL:	**AGENCY NAME:**
SUPERVISOR NAME:	**SUPERVISOR EMAIL:**
ADDRESS:	
CITY:	**ZIP CODE:**
PHONE:	**FAX:**

Indicate type of training class that you need to take:

☐ MDS-HC Assessment ☐ Care Planning ☐ Recertification

Indicate which Regional training you would like to attend:

Choice: ☐ Baton Rouge ☐ Alexandria

Indicate which month you would like to attend:

☐Jan. ☐Feb. ☐March ☐April ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.

Indicate if you have attempted without obtaining certification MDS-HC Assessment, Care Planning or Recertification in the past?

If yes, which one? _____ Date: _____

Please email completed registration form to OAASMDS-HC&CPTRAINING@la.gov . Once we have received your registration form, you will receive a confirmation letter from OAAS, and Trainer will contact you via email to give further information on the training location and schedule.

If you are unable to attend the training class, please email OAASMDS-HC&CPTRAINING@la.gov . If you have any special accommodation needs, please let us know in advance as well.

_____

Section below to be completed by OAAS State Office Designee:

☐ Approved for ☐ MDS-HC Assessment ☐ Care Planning ☐ Recertification

Training Date _____ Location _____

☐ Not approved and Reason: _____

OAAS Representative: _____ Date: _____

*****Attached Training Announcement